Senate Bill No. 367

CHAPTER 723

An act to amend Sections 10123.13, 10123.147, 12921.1, and 12921.3 of, and to add Sections 10123.137, 10133.66, and 10133.67 to, the Insurance Code, relating to health care coverage.

[Approved by Governor October 7, 2005. Filed with Secretary of State October 7, 2005.]

LEGISLATIVE COUNSEL'S DIGEST

SB 367, Speier. Health care complaint system.

Existing law provides for the licensure and regulation of health insurers by the Department of Insurance and requires the Insurance Commissioner to establish a program to investigate and respond to complaints concerning insurers. Under existing law, a health insurer is required to reimburse a provider's complete claim within a specified timeframe or to provide a notice to the provider explaining its reasons for denying or contesting the claim.

This bill would require the commissioner on or before July 1, 2006, to establish an Internet Web page dedicated exclusively to processing complaints and inquiries from insureds and their health care providers relating to health insurance issues and providing information concerning the process for filing complaints and making inquiries concerning health insurers. The bill would also require the commissioner by that date to provide announcements regarding the complaint system and to process those complaints as specified. The bill would also require a health insurer to provide a copy of its notice denying or contesting a provider's claim to each insured who received services and to each provider who provided services pursuant to that particular claim and to include a statement within that notice of the basis for contesting or denying the claim and that the provider or insured may request review by the department of the insurer's action. The bill would also require each contract between a health insurer and a provider to provide for a dispute resolution mechanism, and would require the mechanism to also be available to noncontracting providers. The bill would require annual reports by health insurers to the department in that regard beginning on July 1, 2007.

The bill would incorporate changes made by AB 729 that would become operative if both bills are enacted and this bill is enacted after AB 729.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares the following:

(1) Health care services must be available to Californians without unnecessary administrative procedures, interruptions, or delays.

(2) As of May 2002, the Department of Insurance estimated that it regulated insurers covering 28.79 percent of the total accident and health care market and that, with respect to those commercial products that are comparable between the Department of Insurance and the Department of Managed Health Care regulated products, the Department of Insurance regulated 16.8 percent of the comprehensive commercial health insurance provided to Californians.

(3) With two separate departments responsible for regulating entities that provide health care coverage, patients and their health care providers are often confused about the identity of the appropriate regulator.

(b) It is the intent of the Legislature to reduce confusion about the identity of the appropriate regulator, to provide all patients who have health care coverage and their health care providers with an easy and effective mechanism within the Department of Insurance to effectively resolve complaints as already intended for health care providers through the Department of Managed Health Care, and to assure the public that the law is properly implemented.

SEC. 2. This act shall be known and may be cited as the Patient and Provider Protection Act.

SEC. 3. Section 10123.13 of the Insurance Code is amended to read:

10123.13. (a) Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included

on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. The notice to the insured may also be included on the explanation of benefits.

(b) If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue and shall be payable at the rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(c) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. If an insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 working days of receipt of that information, interest shall accrue and be payable at a rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(d) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

SEC. 4. Section 10123.137 is added to the Insurance Code, to read:

10123.137. (a) Each contract between a health insurer and a provider shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the insurer, and requiring the insurer to inform its providers, upon contracting with the insurer, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(b) An insurer shall also ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(c) Disputes are to be submitted to the insurer in writing and shall include provider name, provider tax identification number, patient name, insurer's identification information, dates of service, description of dispute, and, if applicable, billed and paid amounts. The insurer shall resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.

(d) On and after July 1, 2007, an insurer shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall be public information and include, at a minimum, information on the

number of providers that utilized the dispute resolution mechanism and a summary of the disposition of those disputes. To the extent the commissioner requires detailed information disclosing emerging or established patterns of provider disputes or corrective action by the insurer, the commissioner may maintain the confidentiality of any information found to be proprietary, upon written request of the insurer. In no event shall the commissioner find the required minimum information described in this subdivision to be proprietary.

(e) If an insurer has an affiliated or subsidiary company that is licensed as a health care service plan under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, the insurer may use the same procedures relating to the provider dispute resolution process established by the affiliated or subsidiary entity pursuant to subdivision (h) of Section 1367 of the Health and Safety Code.

SEC. 5. Section 10123.147 of the Insurance Code is amended to read:

10123.147. (a) Every insurer issuing group or individual policies of health insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the insurer. However, an insurer may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the complete claim by the insurer. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial, including the factual and legal basis known at that time by the insurer for each reason. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or legal basis for its reason to deny the claim. The insurer shall provide a copy of the notice required by this subdivision to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice required by this subdivision shall include a statement advising the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that was contested or denied by the insurer and the address, Internet Web site address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. An insurer may delay payment of an uncontested portion of a complete claim for

reconsideration of a contested portion of that claim so long as the insurer pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the insurer has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. However, if the insurer requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the insurer may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. The provider shall provide the insurer reasonable relevant information within 15 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the insurer requires further information, the insurer shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. An insurer shall specify, in a written notice to the provider within 30 working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the insurer shall have 30

working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt of the additional information, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(f) An insurer shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the insurer's actions to resolve the claim, to the provider that submitted the claim.

(g) An insurer shall not request or require that a provider waive its rights pursuant to this section.

(h) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 of the Health and Safety Code in the United States on or after September 1, 1999.

(i) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 10123.13.

(j) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

SEC. 6. Section 10133.66 is added to the Insurance Code, to read:

10133.66. On or before July 1, 2006, the commissioner, pursuant to his or her authority under Section 12921.1, shall also complete all of the following duties:

(a) Provide announcements that inform health insurance consumers and their health care providers of the department's toll-free telephone number that is dedicated to the handling of complaints and of the availability of the Internet Web page established under this section, and the process to register a complaint with the department and to submit an inquiry to it.

(b) Establish an Internet Web page located on the department's public Internet Web site dedicated exclusively to processing complaints and inquiries relating to health insurance issues from insureds and their health care providers. The Web page shall provide insureds and their health care providers with information concerning filing a complaint and making an inquiry concerning a health insurer and, at a minimum, shall provide the following information:

(1) The department's toll-free telephone number.

(2) A list of all health insurers licensed by the department.

(3) Educational and informational guides for health insurance consumers and health care providers describing their rights under this code. The guides shall be easy to read and understand and shall be made

available to the public, including access on the department's Internet Web site.

(4) A separate, standardized complaint form for health care providers to file a complaint.

(c) An insured or health care provider may file a written complaint with the department with respect to the handling of a claim or other obligation under a health insurance policy by a health insurer or production agency, or with respect to the alleged misconduct by a health insurer or production agency. The commissioner shall notify the complainant of the receipt of the complaint within 10 business days of its receipt. The commissioner shall make a determination on the complaint within 60 calendar days of the date of its receipt, unless the commissioner, in his or her discretion, determines that additional time is reasonably necessary to fully and fairly evaluate the complaint. The commissioner shall notify the complainant of the final action taken on his or her complaint within 30 days of the final action. The notification shall include a summary explaining the commissioner's reasons for the final action.

SEC. 7. Section 10133.67 is added to the Insurance Code, to read:

10133.67. Pursuant to Section 12921, the commissioner may also agree to payment to a health care provider who submitted a claim for health care benefits provided to an insured that are covered under the insured's health insurance policy.

SEC. 8. Section 12921.1 of the Insurance Code is amended to read:

12921.1. (a) The commissioner shall establish a program on or before July 1, 1991, to investigate complaints and respond to inquiries received pursuant to Section 12921.3, to comply with Section 12921.4, and, when warranted, to bring enforcement actions against insurers. The program shall include, but not be limited to, the following:

(1) A toll-free telephone number published in telephone books throughout the state, dedicated to the handling of complaints and inquiries.

(2) Public service announcements to inform consumers of the toll-free telephone number and how to register a complaint or make an inquiry to the department.

(3) A simple, standardized complaint form designed to assure that complaints will be properly registered and tracked.

(4) Retention of records on complaints for at least three years after the complaint has been closed.

(5) Guidelines to disseminate complaint and enforcement information on individual insurers to the public, that shall include, but not be limited to, the following:

(A) License status.

(B) Number and type of complaints closed within the last full calendar year, with analogous statistics from the prior two years for comparison. The proportion of those complaints determined by the department to require that corrective action be taken against the insurer, or leading to insurer compromise, or other remedy for the complainant, as compared to those that are found to be without merit. This information shall be

disseminated in a fashion that will facilitate identification of meritless complaints and discourage their consideration by consumers and others interested in the records of insurers.

(C) Number and type of violations found, by reference to the line of insurance and the law violated. For the purposes of this subparagraph, the department shall separately report this information for health insurers.

(D) Number and type of enforcement actions taken.

(E) Ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both. Private passenger automobile insurance ratios shall be calculated as the number of complaints received to total car years earned in the period studied.

(F) Any other information the department deems is appropriate public information regarding the complaint record of the insurer that will assist the public in selecting an insurer. However, nothing in this section shall be construed to permit disclosure of information or documents in the possession of the department to the extent that the information and those documents are protected from disclosure under any other provision of law.

(6) Procedures and average processing times for each step of complaint mediation, investigation, and enforcement. These procedures shall be consistent with those in Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 for complaints within the purview of that article, consistent with those in Article 7 (commencing with Section 1858) of Chapter 9 of Part 2 of Division 1 for complaints within the purview of that article, and consistent with any other provisions of law requiring certain procedures to be followed by the department in investigating or prosecuting complaints against insurers.

(7) A list of criteria to determine which violations should be pursued through enforcement action, and enforcement guidelines that set forth appropriate penalties for violations based on the nature, severity, and frequency of the violations.

(8) Referral of complaints not within the department's jurisdiction to appropriate public and private agencies.

(9) Complaint handling goals that can be tested against surveys carried out pursuant to subdivision (a) of Section 12921.4.

(10) Inclusion in its annual report to the Governor, required by Section 12922, detailed information regarding the program required by this section, that shall include, but not be limited to: a description of the operation of the complaint handling process, listing civil, criminal, and administrative actions taken pursuant to complaints received; the percentage of the department's personnel years devoted to the handling and resolution of complaints; and suggestions for legislation to improve the complaint handling apparatus and to increase the amount of enforcement action undertaken by the department pursuant to complaints if further enforcement is deemed necessary to ensure proper compliance by insurers with the law.

(b) The commissioner shall promulgate a regulation that sets forth the criteria that the department shall apply to determine if a complaint is

deemed to be justified prior to the public release of a complaint against a specifically named insurer.

(c) The commissioner shall provide to the insurer a description of any complaint against the insurer that the commissioner has received and has deemed to be justified at least 30 days prior to public release of a report summarizing the information required by this section. This description shall include all of the following:

(1) The name of the complainant.

(2) The date the complaint was filed.

(3) A succinct description of the facts of the complaint.

(4) A statement of the department's rationale for determining that the complaint was justified that applies the department's criteria to the facts of the complaint.

(d) An insurer shall provide to the department the name, mailing address, telephone number, and facsimile number of a person whom the insurer designates as the recipient of all notices, correspondence, and other contacts from the department concerning complaints described in this section. The insurer may change the designation at any time by providing written notice to the Consumer Services Division of the department.

(e) For the purposes of this section, notices, correspondence, and other contacts with the designated person shall be deemed contact with the insurer.

SEC. 8.5. Section 12921.1 of the Insurance Code is amended to read:

12921.1. (a) The commissioner shall establish a program on or before July 1, 1991, to investigate complaints and respond to inquiries received pursuant to Section 12921.3, to comply with Section 12921.4, and, when warranted, to bring enforcement actions against insurers or production agencies, as those terms are defined in subdivision (a) of Section 1748.5. The program shall include, but not be limited to, the following:

(1) A toll-free telephone number published in telephone books throughout the state, dedicated to the handling of complaints and inquiries.

(2) Public service announcements to inform consumers of the toll-free telephone number and how to register a complaint or make an inquiry to the department.

(3) A simple, standardized complaint form designed to assure that complaints will be properly registered and tracked.

(4) Retention of records on complaints for at least three years after the complaint has been closed.

(5) Guidelines to disseminate complaint and enforcement information on individual insurers to the public, that shall include, but not be limited to, the following:

(A) License status.

(B) Number and type of complaints closed within the last full calendar year, with analogous statistics from the prior two years for comparison. The proportion of those complaints determined by the department to require that corrective action be taken against the insurer, or leading to insurer compromise, or other remedy for the complainant, as compared to

those that are found to be without merit. This information shall be disseminated in a fashion that will facilitate identification of meritless complaints and discourage their consideration by consumers and others interested in the records of insurers.

(C) Number and type of violations found, by reference to the line of insurance and the law violated. For the purposes of this subparagraph, the department shall separately report this information for health insurers.

(D) Number and type of enforcement actions taken.

(E) Ratio of complaints received to total policies in force, or premium dollars paid in a given line, or both. Private passenger automobile insurance ratios shall be calculated as the number of complaints received to total car years earned in the period studied.

(F) Any other information the department deems is appropriate public information regarding the complaint record of the insurer that will assist the public in selecting an insurer. However, nothing in this section shall be construed to permit disclosure of information or documents in the possession of the department to the extent that the information and those documents are protected from disclosure under any other provision of law.

(6) Procedures and average processing times for each step of complaint mediation, investigation, and enforcement. These procedures shall be consistent with those in Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 for complaints within the purview of that article, consistent with those in Article 7 (commencing with Section 1858) of Chapter 9 of Part 2 of Division 1 for complaints within the purview of that article, and consistent with any other provisions of law requiring certain procedures to be followed by the department in investigating or prosecuting complaints against insurers or production agencies.

(7) A list of criteria to determine which violations should be pursued through enforcement action, and enforcement guidelines that set forth appropriate penalties for violations based on the nature, severity, and frequency of the violations.

(8) Referral of complaints not within the department's jurisdiction to appropriate public and private agencies.

(9) Complaint handling goals that can be tested against surveys carried out pursuant to subdivision (a) of Section 12921.4.

(10) Inclusion in its annual report to the Governor, required by Section 12922, detailed information regarding the program required by this section, that shall include, but not be limited to: a description of the operation of the complaint handling process, listing civil, criminal, and administrative actions taken pursuant to complaints received; the percentage of the department's personnel years devoted to the handling and resolution of complaints; and suggestions for legislation to improve the complaint handling apparatus and to increase the amount of enforcement action undertaken by the department pursuant to complaints if further enforcement is deemed necessary to ensure proper compliance by insurers or production agencies with the law.

(b) The commissioner shall promulgate a regulation that sets forth the criteria that the department shall apply to determine if a complaint is deemed to be justified prior to the public release of a complaint against a specifically named insurer or production agency.

(c) The commissioner shall provide to the insurer or production agency a description of any complaint against the insurer or production agency that the commissioner has received and has deemed to be justified at least 30 days prior to public release of a report summarizing the information required by this section. This description shall include all of the following:

(1) The name of the complainant.

(2) The date the complaint was filed.

(3) A succinct description of the facts of the complaint.

(4) A statement of the department's rationale for determining that the complaint was justified that applies the department's criteria to the facts of the complaint.

(d) An insurer shall provide to the department the name, mailing address, telephone number, and facsimile number of a person whom the insurer designates as the recipient of all notices, correspondence, and other contacts from the department concerning complaints described in this section. The insurer may change the designation at any time by providing written notice to the Consumer Services Division of the department.

(e) For the purposes of this section, notices, correspondence, and other contacts with the designated person shall be deemed contact with the insurer.

SEC. 9. Section 12921.3 of the Insurance Code is amended to read:

12921.3. (a) The commissioner, in person or through employees of the department, shall receive complaints and inquiries, investigate complaints, prosecute insurers when appropriate and according to guidelines determined pursuant to Section 12921.1, and respond to complaints and inquiries by members of the public concerning the handling of insurance claims, including, but not limited to, violations of Article 10 (commencing with Section 1861) of Chapter 9 of Part 2 of Division 1, by insurers, or alleged misconduct by insurers or production agencies.

(b) The commissioner shall not decline to investigate complaints for any of the following reasons:

(1) The insured is represented by an attorney in a dispute with an insurer, or is in mediation or arbitration.

(2) The insured has a civil action against an insurer.

(3) The complaint is from an attorney, if the complaint is based upon evidence or reasonable beliefs about violations of law known to an attorney because of a civil action.

(c) The commissioner may defer the investigation until the finality of a dispute, mediation, arbitration, or civil action involving the claim is known.

(d) The commissioner, as he or she deems appropriate, and pursuant to Section 12921.1, shall provide for the education of, and dissemination of

information to, members of the general public or licensees of the department concerning insurance matters.

SEC. 9.5. Section 12921.3 of the Insurance Code is amended to read:

12921.3. (a) The commissioner, in person or through employees of the department, shall receive complaints and inquiries, investigate complaints, prosecute insurers or production agencies when appropriate and according to guidelines determined pursuant to Section 12921.1, and respond to complaints and inquiries by members of the public concerning the handling of insurance claims, including, but not limited to, violations of Article 10 (commencing with Section 1861) of Chapter 9 of Part 2 of Division 1, by insurers or production agencies, or alleged misconduct by insurers or production agencies.

(b) The commissioner shall not decline to investigate complaints for any of the following reasons:

(1) The insured is represented by an attorney in a dispute with an insurer, or is in mediation or arbitration.

(2) The insured has a civil action against an insurer.

(3) The complaint is from an attorney, if the complaint is based upon evidence or reasonable beliefs about violations of law known to an attorney because of a civil action.

(c) The commissioner may defer the investigation until the finality of a dispute, mediation, arbitration, or civil action involving the claim is known.

(d) The commissioner, as he or she deems appropriate, and pursuant to Section 12921.1, shall provide for the education of, and dissemination of information to, members of the general public or licensees of the department concerning insurance matters.

SEC. 10. Section 8.5 of this bill incorporates amendments to Section 12921.1 of the Insurance Code proposed by both this bill and AB 729. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2006, (2) each bill amends Section 12921.1 of the Insurance Code, and (3) this bill is enacted after AB 729, in which case Section 8 of this bill shall not become operative.

SEC. 11. Section 9.5 of this bill incorporates amendments to Section 12921.3 of the Insurance Code proposed by both this bill and AB 729. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2006, (2) each bill amends Section 12921.3 of the Insurance Code, and (3) this bill is enacted after AB 729, in which case Section 9 of this bill shall not become operative.

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